
Study of Medical Savings Accounts

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 03-14
October 2003



THE AUDITOR
STATE OF HAWAII

Office of the Auditor

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THE AUDITOR

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OVERVIEW

Study of Medical Savings Accounts

Report No. 03-14, October 2003

Summary

We examined the feasibility of medical savings accounts as proposed in various legislative measures regarding workers' compensation, health care insurance, and the Hawaii Employer-Union Health Benefits Trust Fund. Concerned with potential legal, social, and financial impacts of these legislative measures, the 2003 Legislature requested this examination in House Concurrent Resolution No. 93. The report presents our findings on the legal, social, and financial impacts of medical savings accounts.

Generally, medical savings accounts are funds held in trust for individuals insured under high-deductible health insurance policies. Accounts are owned by the insured and used for routine health care expenses; catastrophic medical expenses are covered by their high-deductible health insurance policy. Medical savings accounts are intended to encourage individuals to spend moneys prudently for health care expenses.

Legislation establishing medical savings account arrangements may face legal hurdles under the Employee Retirement Income Security Act (ERISA) and the Hawaii Prepaid Health Care Act. Under ERISA, such legislation may be considered as establishing employee benefit plans and are therefore superseded by the federal law. Under the Hawaii Prepaid Health Care Act, medical savings account insurance products authorized by such legislation may not meet the requirements for approval by the Department of Labor and Industrial Relations.

We found that the legal issues related to medical savings accounts are unresolved and subject to interpretation. We concluded that legislation authorizing the establishment of medical savings accounts will very likely not impair the exemption from ERISA preemption that the Hawaii Prepaid Health Care Act now has. However, the legislation itself may be preempted under ERISA, depending on the nature of the legislation. The Legislature must determine which legal opinion it will rely on when making decisions regarding medical savings accounts.

Some legal uncertainty surrounds medical savings account legislation. This situation arises from the differing readings each legislative measure may have, and can very likely hinder the pace of medical savings account implementation. If passed, enabling legislation only begins the process by which medical savings account health care packages become a reality. These packages require scrutiny by and approval from the insurance commissioner and the Department of Labor and Industrial Relations, including review by the Prepaid Health Care Advisory Council. Largely discretionary, the approval process may raise even more uncertainties.



We also found that, given the limited interest in medical savings accounts nationwide, and very likely in Hawaii, the potential for any negative social and financial impacts of medical savings accounts in Hawaii appears to be minimal. However, cautious consideration of the social and financial impacts of medical savings accounts is warranted. If medical savings accounts are established in Hawaii, the experience of other states may well be repeated here—in which case, medical savings accounts should have little or no impact on health care costs or practices because of relatively low usage.

Recommendations and Response

The Department of Commerce and Consumer Affairs generally agrees with our findings. The department does, however, believe that no additional enabling legislation is required to implement medical savings accounts. It supports its position by citing the state attorney general and the U.S. Department of Labor. We point out that the statements of these two agencies, in opinions given to the department as well as in separate opinions given to the Office of the Auditor, were made in the context of assessing proposed enabling legislation. Therefore, the department's basis for stating that additional enabling legislation is not required is misleading.

The department also comments that all new health plans, not only those with medical savings accounts, must be approved by the director of labor and industrial relations and must meet the requirements of the Hawaii Prepaid Health Care Act. We made a similar observation, but only after noting the attorney general's belief that new health care insurance contracts combined with medical savings accounts can satisfy the requirements of the act—if such contracts provide benefits required under the act and do not conflict with other requirements of the act. As we noted, the attorney general's qualifying statements appear applicable to *any* health care plan proposal presented to the Department of Labor and Industrial Relations.

The Department of Commerce and Consumer Affairs goes further than our finding of minimal potential for any negative social and financial impacts of medical savings accounts. The department believes that medical savings accounts would not have *any* negative social or financial impacts. And, in fact, it believes that medical savings accounts would have a positive impact. However, we stand by our balanced presentation of advantages *and* disadvantages of medical savings accounts.

Finally, we note the attorney general's correction of an editing error in his opinion included in our report as Appendix A. His correcting letter is included in this report in Attachment 2, with the agency response from the Department of Commerce and Consumer Affairs.

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Submitted by

THE AUDITOR
STATE OF HAWAII

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Foreword

This report examines the feasibility of medical savings accounts as proposed in various legislative measures regarding workers' compensation, health care insurance, and the Hawaii Employer-Union Health Benefits Trust Fund. Concerned with potential legal, social, and financial impacts of these legislative measures, the 2003 Legislature requested this examination in House Concurrent Resolution No. 93. The report presents our findings on the legal, social, and financial impacts of medical savings accounts.

We acknowledge the cooperation of the Department of Commerce and Consumer Affairs and other organizations and individuals whom we contacted during the course of our examination.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

Generally, medical savings accounts are funds held in trust for individuals insured under high-deductible health insurance policies. Accounts are owned by the insured and used for routine health care expenses; catastrophic medical expenses are covered by their high-deductible health insurance policy. Medical savings accounts are intended to encourage individuals to spend moneys prudently for health care expenses.

The concept of medical savings accounts is not new. Private sector plans with medical savings accounts began to appear in the 1980s to early 1990s. Most notable were plans developed by Golden Rule Insurance Company and Dominion Resources, both of which offered such plans to their own employees. Also in the 1990s, some states began passing legislation enabling the establishment of medical savings accounts and, in certain cases, providing tax advantages for account holders. A similar effort at the federal level was also developing during this decade.

Hawaii does not currently use medical savings accounts to fund health care costs. However, experience with medical savings accounts on a national level has increased both interest and concerns with implementation in Hawaii. For example, potential tax benefits have made medical savings accounts attractive to some individuals, but the adequacy and affordability of health care for medical savings account holders have also come into question.

Potential legal, social, and financial concerns led the 2003 Legislature to pass House Concurrent Resolution (HCR) No. 93. The resolution asks the State Auditor to conduct a social and financial analysis of the impact that medical savings accounts would have on the Hawaii Prepaid Health Care Act. In addition, the State Auditor is to conduct a legal analysis of the effect that certain proposed legislation may have on existing law related to health care benefits.

For purposes of this analysis, HCR No. 93 directs the State Auditor to examine the feasibility of medical savings accounts as proposed in:

- House Bill No. 450 (authorizing medical trust accounts for workers' compensation purposes),
- House Bill No. 1167 (authorizing health care insurers to offer high-deductible health insurance contracts in conjunction with medical savings accounts), and

- House Bill No. 1293 (establishing medical savings accounts in the Hawaii Employer-Union Health Benefits Trust Fund).

A medical savings account is purely a means of financing health care services; it is not a service in and of itself. Nevertheless, the Legislature requested that we use criteria set forth in Section 23-52, Hawaii Revised Statutes (HRS) for the purposes of our study. These criteria are typically used for mandatory health insurance analyses.

Background on Medical Savings Accounts

Archer MSAs

During the 1990s, Congress considered different legislative measures to address the nation's health care problems. The result of this effort is the Health Insurance Portability and Accountability Act (HIPAA), passed in 1996. Among other things, HIPAA ensures the availability and renewability of health insurance coverage for certain employees and individuals and limits the use of preexisting condition restrictions.

HIPAA also provides for the use of medical savings accounts, but only under the confines of a pilot project that is scheduled to sunset December 31, 2003. Under HIPAA, the aim of medical savings accounts is to improve long-term care accessibility. Medical savings accounts are also intended to provide a health insurance option to the self-employed, many of whom are uninsured, and to employers who may not be sponsoring any employee health benefit plans.

Called *Archer medical savings accounts*, or *Archer MSAs*, in honor of Representative Bill Archer's role in the legislation, this breed of medical savings accounts carries certain federal tax advantages. A medical savings account must meet federal requirements to be considered an Archer MSA and to qualify for these tax advantages.

Medical savings account insurance products existed at the state level, even before the passage of HIPAA. Unless federal requirements are met, however, these state-created medical savings accounts are not eligible for the federal tax advantages available under HIPAA. Because of these special tax advantages, medical savings accounts are often called *medical IRAs*.

Benefits of and restrictions on Archer MSAs

An Archer MSA provides the following benefits: interest or other earnings on assets in the account are tax-free; contributions to the account, although limited by law, are tax-deductible and remain in the account from year-to-year until they are used. In addition, the account is “portable”—that is, it stays with an insured person from job-to-job or even into unemployment status.

Archer MSAs also have certain restrictions. Under the federal pilot project, only two categories of individuals are eligible to establish Archer MSAs: the self-employed and employees of small employers who provide health plans that meet Archer MSA requirements. A “small employer” is generally an employer with an average of 50 or fewer employees during the last two calendar years. Individuals previously uninsured are not counted toward the enrollment limits set by Congress for the pilot project. Participation is limited to 750,000 account holders. Although recent figures suggest that as many as 100,000 Archer MSAs have been opened, this figure is still far below the statutory participation limit.

An Archer MSA must be used in combination with a high-deductible health insurance policy. A policyholder is ineligible for an Archer MSA if the individual is also covered under another health plan that is not high-deductible. The permissible range of high-deductible amounts has changed over time for Archer MSA plans. For 2003, an Archer MSA must be paired with a health insurance policy that has an annual individual deductible amount of at least \$1,700 but not more than \$2,500; annual out-of-pocket expenses may not exceed \$3,350. For family coverage, the deductible range is \$3,350 to \$5,050 and the annual out-of-pocket expense ceiling is \$6,150.

An Archer MSA must be administered by a U.S. financial institution, such as a bank or insurance company. Contributions to the account may be made by either employee or employer, but not both. Limits apply to the amount that can be contributed to an Archer MSA: 75 percent of a plan’s deductible for family plans and 65 percent for a self-only plan. In addition, the policyholder must have insurance all year or the contribution amount is prorated.

Account funds must be used for qualified medical expenses or they lose their tax advantages. A stiff penalty is also imposed on funds that are used for non-qualifying purposes. Qualified medical expenses, however, are defined rather broadly under Internal Revenue Code Section 213(d).

How Archer MSA plans work

An Archer MSA is intended to control health care costs in the following way: An employer purchases a less expensive high-deductible health care plan and sets up an Archer MSA for an employee. With the money saved on less expensive premiums, the employer may choose to make a contribution to the employee's Archer MSA. Or the employee can contribute to the account, but only if the employer does not. These contributions are tax deductible.

While the high-deductible insurance covers catastrophic illnesses and other large medical expenses, the employee pays for routine health care expenses from the account or from other personal resources until the annual out-of-pocket ceiling is reached. Thereafter, the insurance policy covers health care expenses, either completely or on a co-payment basis (depending on the terms of the policy). This arrangement is intended to encourage the employee to spend more prudently for health care needs.

Interest on funds in the account accumulates tax-free. Funds remaining in the account at year's end, and even after termination or upon unemployment, are still eligible for use by the employee. However, to continue enjoying the tax advantages of an Archer MSA in another employment situation, the account holder must continue to be an eligible individual—that is, re-employed by a small employer or self-employed. While unemployed, the individual may use account funds to purchase health care coverage on a tax-free basis. See examples below.

Example No. 1

Under a health care plan with a medical savings account, Susan Lee elects a high deductible of \$2,250 (she could elect one up to \$2,500 for 2003). Her monthly premiums are \$159 (\$1,908 per year). She funds her medical savings account in the amount of \$1,463 (65 percent of her deductible, the maximum allowed under federal law). This plan has an annual out-of-pocket expense ceiling of \$3,100, meaning Susan must pay up to \$2,250 for each medical expense occurrence until she hits the ceiling of \$3,100 for the year. But Susan uses her medical savings account funds for these expenses. Assuming Susan has out-of-pocket expenses of \$1,000 for the year and is in the 28 percent tax bracket, her savings would be \$730 in federal taxes (28 percent of the total of 60 percent of her premiums plus 100 percent of her MSA contribution). In addition, she has \$463 remaining in her account for her continued use. And next year she can contribute another \$1,463 to her medical savings account.

Example No. 2

John Smart, a computer software consultant, buys a medical savings account plan with a high deductible of \$4,500 for his family (he could have elected a plan with a deductible up to \$5,050). The Smarts pay a monthly premium of \$184 (\$2,208 per annum). Over the year, they deposit the maximum contribution of \$3,375 into their medical savings account (for families, the contribution maximum is 75 percent of the deductible). With out-of-pocket expenses for the year of \$1,000, the Smarts have \$2,375 remaining in their medical savings account at year-end, which rolls over into the next year. During that next year, they can contribute another \$3,375 into their account. Using the same tax assumptions as in Example No. 1, the Smarts have saved \$1,316 in federal taxes.

***Relationship of ERISA,
the Hawaii Prepaid
Health Care Act, and
Archer MSAs***

Legislation establishing Archer MSAs or other medical savings account arrangements may face legal hurdles under the federal Employee Retirement Income Security Act (ERISA) and the Hawaii Prepaid Health Care Act. Under ERISA, such legislation may be considered as establishing employee benefit plans and are therefore superseded by the federal law. Under the Hawaii Prepaid Health Care Act, medical savings account insurance products authorized by such legislation may not meet the requirements for approval by the director of labor and industrial relations.

Medical savings accounts work in conjunction with high-deductible health care plans. ERISA regulates such plans and all other private sector benefit plans. Its comprehensive regulatory scheme is intended to protect employers from inconsistent state and local laws governing employee benefits, including health care benefits. To ensure regulatory uniformity among the states, Congress included a preemption clause in ERISA. The clause provides that the act shall supersede any and all state laws that relate to any employee benefit plan.

The Hawaii Prepaid Health Care Act, passed in 1974, requires employers to provide a qualified prepaid health care plan to regular employees who work at least 20 hours per week. Federal courts have ruled that the Prepaid Health Care Act is superseded by ERISA. A subsequent congressional amendment exempted the act from ERISA's preemptive effect. The exemption, however, applies only to the act as it read in 1974. In effect, ERISA has frozen the Hawaii law at its original provisions, since ERISA would override any subsequent amendments. It is possible, therefore, that in Hawaii any law passed after 1974 that could be viewed as amending the Prepaid Health Care Act may be challenged under ERISA's preemption clause.

Under the Prepaid Health Care Act, all new health care plans proposing

to incorporate medical savings accounts require review and approval by the director of labor and industrial relations. The director administers and enforces the Hawaii Prepaid Health Care Act. He is advised by the Prepaid Health Care Advisory Council on whether proposed health care plans comply with statutory standards. Council members, not to exceed seven in number, are appointed by the director. By statute, this advisory body comprises representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection.¹

The department's review determines whether, under the Hawaii Prepaid Health Care Act, a proposed plan is one with benefits that are equal to, or are medically reasonable substitutes for, the benefits provided by the plan with the largest number of subscribers in Hawaii. Alternatively, the review determines whether a plan satisfactorily provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included.²

This review process begins with the Prepaid Health Care Advisory Council. The advisory body provides written advice to the director, who proposes approval or disapproval of the plan. The department gives health care contractors the opportunity to request reconsideration of any proposed disapproval. Thereafter, the director issues a final decision approving or disapproving the proposed plan.

Medical savings account legislation

Certain measures establishing medical savings accounts raised a number of legal, social, and financial concerns for the Legislature during the 2003 session. These measures were House Bill No. 450 (authorizing medical trust accounts for workers' compensation), House Bill No. 1167 (authorizing insurers to offer medical savings account products), and House Bill No. 1293 (establishing medical savings accounts in the employer-union health benefits trust fund). In the following sections, we describe the bills more fully and highlight their legislative concerns.

House Bill No. 450

Finding the current workers' compensation system "unwieldy and expensive," the Legislature proposed House Bill No. 450 during the 2003 session. The bill would authorize employers to create, for workers' compensation purposes, individual medical trust accounts for each of their employees' health care expenses. Funds in these accounts appear to be intended to cover injuries "short of a catastrophic injury" and for the first \$3,000 of catastrophic work-related injuries. Apparently, the present workers' compensation structure would be retained for catastrophic injuries above the \$3,000 threshold. This proposed medical

trust account structure appears to be an option, not mandatory, for employers in meeting their workers' compensation obligations.

The Legislature believes this new structure would:

- eliminate litigation of less severe injuries,
- reduce workers' compensation costs through a higher deductible, for which funds in a medical trust account would compensate,
- promote prudent spending for more common and less serious personal injuries by providing an annual bonus of 5 percent and payouts near or after retirement age, and
- by these benefits, provide an incentive to employees to avoid on-the-job injuries.

Employers who choose to provide their employees with medical trust accounts would set up accounts with a financial or trust institution as trustee. Employers would contribute an amount determined by the insurance commissioner, in consultation with an actuary. Under this arrangement, employees who suffer *temporary* work-related injury or disease would use the first \$3,000 in the account for medical care and lost weekly wages. The existing workers' compensation system would cover work-related injuries or diseases that result in death or *permanent* loss or impairment. It would also cover catastrophic work-related injuries beyond the first \$3,000. Reimbursements of medical expenses and lost wages from a medical trust account would be excluded from state income tax.

Funds in the account could be used for other purposes as well. An employer's contributions could be refunded if an employee suffered permanent total disability and was unable to work. In addition, an employee could withdraw a portion of the funds at certain benchmarks, such as at age 60.

House Bill No. 1167

Hawaii's income tax law already incorporates, for state tax purposes, the federal statute that establishes Archer MSAs.³ Since medical savings accounts are not acknowledged elsewhere in Hawaii law, some confusion may arise as to whether insurers may offer high-deductible health care insurance in conjunction with medical savings accounts. To eliminate any confusion, the Legislature introduced House Bill No. 1167.

This bill amends the insurance code (Chapter 431, HRS) to allow insurance companies to offer high-deductible health insurance contracts

that establish medical savings accounts. The bill also makes parallel amendments to Chapter 432, HRS to authorize mutual benefit societies and to Chapter 432D, HRS to authorize health maintenance organizations.

Medical savings accounts established pursuant to this bill would be eligible for federal tax advantages, to the extent that requisite federal requirements were met. For example, the high deductible amount under an insurance policy would have to be within the acceptable range for Archer MSAs; contributions could not exceed the allowable percentage of the deductible; and the policyholder would have to be self-employed or an employee of a small employer.

House Bill No. 1293

House Bill No. 1293 would amend Chapter 87A, HRS relating to the Hawaii Employer-Union Health Benefits Trust Fund. The amendment would provide for establishment of medical savings accounts as a means for public employees to pay for health care expenses.

The bill defines, among other terms, a “high-deductible health plan” by establishing the applicable annual deductible amount and out-of-pocket expense ceilings for individual and family coverage. A medical savings account plan would be an option that must be offered by the trust fund. The trust fund would also be directed to establish rules for the administration of a medical savings account plan.

The bill does not specify the amount to be contributed to a medical savings account on behalf of a public employee. It does, however, direct *the employer of the employee* to make contributions into the account. There are no provisions for employee contributions. At the end of each calendar year, the employee would be paid any balance remaining in the employee’s medical savings account.

We note that the medical savings accounts established under this bill for public employees would not be eligible for the tax advantages given to Archer MSAs. The “employer” under this bill is a government entity, and Archer MSAs are intended for employees of “small employers”—those with fewer than 50 employees.

Legal concerns

Legal concerns stem from the possible preemptive effect of ERISA and the review process required of new health care plans under the Hawaii Prepaid Health Care Act. A court of law could read the proposed legislative measures described above as, in effect, amendments to the health care act. This possibility raises the legislative concern that these measures, if passed, may jeopardize the exemption from ERISA

preemption that the health care act currently has. Another concern is that these legislative measures themselves may be superseded by ERISA if they are read as amending the Hawaii act.

The Legislature has an additional concern regarding the acceptability of medical savings account insurance products under the Prepaid Health Care Act. The director of labor and industrial relations (with advice from the Prepaid Health Care Advisory Council) must examine proposed health care plans to see if they meet standards set by the health care act. Whether new health care plans with Archer MSAs will be acceptable to the department is not clear. For instance, in 1997, a plan incorporating medical savings accounts proposed by University Health Alliance failed to gain the required approval.

Social and financial concerns

There is also uncertainty that the proposed legislative measures may be read as mandating health insurance coverage and thereby require a study under Section 23-51, HRS. This uncertainty prompted the Legislature to request that the State Auditor “conduct a social and financial analysis of the impact medical savings accounts would have on the Health Care Act.”

Regardless of the statute’s applicability, the proposed measures raised social and financial concerns for the Legislature. As House Concurrent Resolution No. 93 points out, the high-deductible insurance that must accompany medical savings accounts may mean financial losses for some employees. In addition, insurance rates may be impacted for those who choose to stay with traditional comprehensive health insurance plans, if risks shift away from those opting for high-deductible insurance.

Objectives of the Study

The objectives of this study are to:

1. Describe the potential legal, social, and financial impacts of medical savings accounts.
2. Make recommendations as appropriate.

Scope and Methodology

Our study examined the legal, social, and financial impacts of establishing Archer MSAs in health care plans and medical savings accounts in workers’ compensation packages and in government employee health care plans. The legal implications considered were limited to ERISA preemption issues and the acceptability of medical

savings accounts under the Prepaid Health Care Act. Because of the nature of this study, our report presents conclusion statements rather than recommendations, which we deemed more appropriate.

For the ERISA preemption issues, we requested the legal opinion of the state attorney general. We also asked for a statement from the U.S. Department of Labor on these issues, since this federal agency is responsible for administering health plans under ERISA. In addition, we interviewed the director of labor and industrial relations regarding the process by which a health care plan proposing medical savings accounts might be reviewed and approved.

We reviewed literature to determine the positive and negative social and financial aspects of medical savings accounts. We also surveyed other states, as well as local health care insurance entities and representatives of labor unions and employer organizations, to understand their experiences with and views on the social and financial effects of medical savings accounts.

To assess the potential social and financial effects of medical savings accounts, we used the following criteria set forth in Section 23-52, HRS to the extent feasible:

Social impact

1. Extent to which medical savings accounts would generally be utilized by a significant portion of Hawaii's population.
2. Extent to which medical savings accounts are already generally available.
3. Extent to which the lack of medical savings accounts would result in persons being unable to obtain necessary health care treatment.
4. If medical savings accounts were not generally available, the extent to which the lack of medical savings accounts would result in unreasonable financial hardship on those persons needing treatment.
5. Level of public demand for medical savings accounts.
6. Level of public demand for individual and group insurance coverage in relation to medical savings accounts.
7. Level of interest of collective bargaining organizations in negotiating privately for inclusion of medical savings accounts in group contracts.

8. Impact of medical savings accounts on health status, quality of care, practice patterns, or provider competition.
9. Impact of indirect costs upon the costs and benefits of medical savings accounts.

Financial impact

1. Extent to which medical savings accounts would increase or decrease health care costs.
2. Extent to which medical savings accounts might increase the use of health care services.
3. Extent to which medical savings accounts might serve as an alternative for more expensive treatment or service.
4. Extent to which medical savings accounts might increase or decrease insurance premiums or administrative expenses of policyholders.
5. Impact of medical savings accounts on the total cost of health care.

Our work was conducted from May 2003 to September 2003 according to generally accepted government auditing standards.

Chapter 2

Legal, Social, and Financial Impacts of Medical Savings Accounts

A medical savings account is seen by some as a means to give the insured more responsibility in deciding how to spend their health care dollars. In theory, greater involvement in decision-making should motivate more prudent spending by the insured. The anticipated outcome would be an overall reduction in health care costs. We found, however, that determining the positive and negative aspects of medical savings accounts remains a complex task.

Summary of Findings

1. Legal issues related to medical savings accounts are unresolved and subject to interpretation.
2. Given the limited interest in medical savings accounts nationwide, and very likely in Hawaii, the potential for any negative social and financial impacts of medical savings accounts in Hawaii appears to be minimal.

The Legal Ramifications of Medical Savings Accounts in Hawaii Are Untested

Although other states have already implemented medical savings accounts, Hawaii has not; and enactment of laws enabling the establishment of medical savings account would have uncertain legal ramifications. The health care environment in Hawaii is unique among states: first, the Hawaii Prepaid Health Care Act is the only statute in the nation that requires private employers to provide health insurance coverage to their employees; second, Hawaii is the only state that has an exemption to ERISA's preemption of state employee benefit laws.

During its 2003 session, the Legislature introduced certain bills to allow (1) health care plan providers to offer health insurance contracts that establish Archer MSAs; (2) employers to establish a medical trust account for each employee for workers' compensation purposes; and (3) the employer-union health benefits trust fund to establish a medical savings account plan option for government employees.

These bills, none of which were passed, do not amend the Prepaid Health Care Act directly. The Legislature, however, was concerned that any legislation allowing medical savings accounts may be construed by a federal court as amending the act, thereby possibly jeopardizing the act's exemption from ERISA preemption.

The Department of Commerce and Consumer Affairs presented letters from the state attorney general and the U.S. Department of Labor as part of its testimony in support of medical savings account bills. These letters seem to suggest that the Hawaii Prepaid Health Care Act would not impede establishment of medical savings accounts, and legislation allowing the establishment of medical savings accounts would not jeopardize Hawaii's exemption from ERISA's preemptive effect.

Some uncertainty arose, however, about whether the letters truly address the legal issues at hand. For instance, the letters did not reveal the context in which they were written, nor the specific questions posed by the Department of Commerce and Consumer Affairs to the state attorney general and the U.S. Department of Labor.

Whether a particular law escapes ERISA preemption depends to a large extent on the interpretation of its particular provisions. Opinions and statements from the state attorney general and the U.S. Department of Labor that we obtained reflect this view regarding ERISA preemption. In short, any legal impact cannot easily be predicted.

Legal opinion of the attorney general

In response to our inquiry, the attorney general was clear that medical savings account legislation will not affect the exemption from ERISA preemption now accorded the Hawaii Prepaid Health Care Act. However, he is less certain about whether the bills under consideration can themselves escape ERISA preemption. He also believes that a medical savings account package could be approved by the Department of Labor and Industrial Relations. His qualifying statements, however, appear applicable to *any* health care plan proposal presented to the department—which leaves a medical savings account package as uncertain as any other proposal seeking departmental approval. (See Appendix A for the attorney general's letter.)

The attorney general refrained from giving an overall opinion on the likelihood that medical savings account legislation might be preempted by ERISA. Rather, he examined each legislative measure individually. The attorney general cautioned that a court of law may not agree with his ERISA preemption analysis should the subject bills become law and are then challenged.

House Bill No. 450 would authorize medical trust accounts for workers' compensation purposes. The attorney general's opinion is that, if enacted, this legislation would likely face ERISA preemption because it provides for employee benefits that ERISA exclusively governs. If the bill provided an employee benefit plan solely for the purpose of complying with applicable workers' compensation laws, ERISA would not apply at all. However, the bill additionally provides employee

benefits that are outside the purposes of Hawaii's workers' compensation law. For example, the bill authorizes payment from a medical trust account to an employee upon retirement.

House Bill No. 1167 would allow health care insurers to offer medical savings accounts products with high-deductible health insurance contracts. The attorney general opines that this bill, if enacted, would probably escape preemption. ERISA recognizes that states regulate the business of insurance and excludes related laws from preemption. Since the legislation is directed to entities that are engaged in the business of insurance, it is thus saved from ERISA preemption.

House Bill No. 1293 requires the employer-union health benefits trust fund to offer medical savings account plans as an option to public employees. In the attorney general's opinion, this legislation, if enacted, would fall outside the scope of ERISA and therefore not be subject to preemption. The employee benefit plan established by the bill is a *governmental plan*, and ERISA does not regulate such plans.

The attorney general believes that new health care insurance contracts combined with medical savings accounts can satisfy the requirements of the Hawaii Prepaid Health Care Act. He points out that the director of labor and industrial relations, with input from the Prepaid Health Care Advisory Council, has some flexibility in approving new health care plans. This flexibility would allow employers to offer high-deductible health insurance coverage together with medical savings accounts that comply with the Prepaid Health Care Act.

Nonetheless, the attorney general qualifies his statement. The plan would have to provide benefits required under the Prepaid Health Care Act and not conflict with other requirements of the act; and the director would have to be satisfied with the limitations, co-insurance, and deductibles of the plan. All of these qualifications leave the plan's approval in doubt.

***Legal opinion of the
U.S. Department of
Labor***

The U.S. Department of Labor appears in agreement with the opinion expressed by the attorney general—first, that legislation allowing insurers to offer high-deductible health insurance contracts with medical savings accounts would probably not be preempted by ERISA; and second, that such legislation would not affect the exemption from preemption given to the Hawaii Prepaid Health Care Act. (See Appendix B for the letter from the U.S. Department of Labor.)

More specifically, the U.S. Department of Labor's view is that the Hawaii Prepaid Health Care Act does not necessarily lose its exemption from ERISA preemption just because a new law amending the Hawaii

act is itself superseded by ERISA. The department cited a federal district court decision in which an amendment to the act was deemed preempted by ERISA. The court did not suggest that pre-amendment portions of the act were similarly affected.¹

The department also believes that Hawaii's exemption would not be harmed if an amendment to Hawaii's insurance code were to have an indirect effect on the Hawaii Prepaid Health Care Act. House Bill No. 1167 would amend Hawaii's insurance code and allow insurers to offer medical savings account products to employers. As the U.S. Department of Labor pointed out, the amendment would fall within a state's right to regulate the business of insurance. The mere use of the new insurance product by employers in providing health care benefits to their employees does not take the amendment outside a state's right to regulate the business of insurance.

Whether ERISA preemption applies to medical savings account legislation depends on the specific language of the legislation in question. The department, accordingly, refrained from a general answer to our question as to whether medical savings account legislation directly amending the Hawaii act would be preempted under ERISA.

Other considerations

If legislation establishing medical savings accounts is enacted, other considerations may be pertinent to successful implementation. The perspective of the labor department's director would be illuminating to prospective providers of medical savings account health care plans. In addition, certain guidelines may be helpful in developing new health care plans with medical savings accounts.

The director of Hawaii's labor department supports medical savings accounts

The director of labor and industrial relations has indicated his willingness to work with health care insurers to develop a plan incorporating medical savings accounts that would be viewed favorably by the Prepaid Health Care Advisory Council. The director points out, however, the lack of local history on the use or effectiveness of medical savings accounts raises uncertainties. These uncertainties would affect the department's view of new plans with medical savings accounts.

In reviewing a new plan, the department would ascertain that certain mandatory health care benefits are included. Under the Prepaid Health Care Act, the plan can meet this requirement by being "equal to, or medically reasonably substitutable for," the benefits provided by the dominant health care plan in the state (that is, the plan that has the largest number of subscribers in the state). (These are known as *(a)-status*

plans.) Or, a plan can demonstrate to the satisfaction of the director that it qualifies by providing for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included, taking into account the limitations, co-insurance features, and deductibles specified in such plans (known as *(b)-status* plans).²

Currently, the highest deductible under (b)-status plans is \$250; for (a)-status plans it is \$100. An Archer MSA must be paired with a high deductible within the range of \$1,700 to \$2,500 for self-only plans; the range for family coverage is \$3,350 to \$5,050.

In 1997, University Health Alliance submitted a health care plan that incorporated medical savings accounts. The deductible under its plan was \$2,250, which the Prepaid Health Care Advisory Council deemed high. The council's position at the time was that deductibles over \$200 would preclude home and office visits, which are required benefits under the Prepaid Health Care Act. For this reason, among eight others, the council recommended the plan's disapproval. University Health Alliance did not pursue further action on its proposed plan.

The director relies on the expertise of the Prepaid Health Care Advisory Council in determining whether proposed plans are "medically reasonably substitutable" for the dominant plan in the state.³ Although, to date, department directors have not acted against the council's advice, the current director feels it is his duty and responsibility to execute the administration's policies. Accordingly, if a plan incorporating medical savings accounts is rejected by the council, the director intends to work with the plan provider to achieve a package that the council would find acceptable.

Guidelines from the American Academy of Actuaries can assist with implementation

A study by the American Academy of Actuaries suggests considerations that are pertinent in deciding whether a medical savings account plan would be practicable in a particular situation.⁴ These can serve as guidelines for employers contemplating health care plans incorporating medical savings accounts:

- *Total Medical Costs:* Total costs associated with a plan that incorporates medical savings accounts should be compared with total costs of other types of insurance coverage, including the one currently in place. Costs should include premium cost, payments into a medical savings account, out-of-pocket expenses, and the corridor (difference between the deductible and total contributions to the medical savings account).

- *Tax Considerations:* Tax consequences should be identified for both employers and employees. Particular laws in place should be examined for costs and benefits accruable to different parties.
- *Administrative Expenses:* Administrative costs to combine a medical savings account with health care insurance should be determined. Although lower costs may be involved in claims processing (since medical savings account funds are used to cover deductible amounts), setting up an account may entail additional expenses. Total administrative costs are critical to the analysis.
- *Vesting:* Estimates of remainder funds in medical savings accounts may be pertinent to employers. These funds are unrecoverable by employers, since they revert to the employee.

Conclusion on legal impacts

Legislation authorizing the establishment of medical savings accounts will very likely not impair the exemption from ERISA preemption that the Hawaii Prepaid Health Care Act has been given. However, the legislation itself may be preempted under ERISA, depending on the nature of the legislation. The Legislature must determine which legal opinion it will rely on when making decisions regarding medical savings accounts.

Some legal uncertainty surrounds medical savings account legislation. This situation arises from the differing readings each legislative measure may have, and can very likely hinder the pace of medical savings account implementation. If passed, enabling legislation only begins the process by which medical savings account health care packages become a reality. These packages must receive approval from the insurance commissioner and the Department of Labor and Industrial Relations, including review by the Prepaid Health Care Advisory Council. Largely discretionary, the approval process may raise even more uncertainties.

Social and Financial Impacts

A number of states have already legislated medical savings account usage, some even before the enactment of HIPAA. As many as 26 other states have some form of medical savings account laws, at least 11 of which are compatible with HIPAA requirements for Archer MSAs. This activity at the state level is interesting, particularly in light of states' relatively low income tax rates. The attractiveness of Archer MSAs rests largely on their tax advantages; yet the same kinds of advantages would be limited at the state level precisely because of their low tax rates.

States have traditionally regulated health insurance, and many have legislated reforms to expand insurance availability and ensure equity in the health care environment. A natural consequence of this state-level interest would appear to be the consideration of medical savings account use. Generally, however, states most active in insurance reform are less likely to have enacted legislation regarding medical savings accounts. A policy analysis of the Urban Institute concludes that this is “not surprising, since [medical savings accounts] and other insurance reforms represent competing philosophies.”⁵

The philosophical difference that divides proponents and critics of medical savings accounts affects the degree to which this health care funding device is accepted and promoted. As one health care expert notes:

The political fight over [medical savings accounts] in Congress remained fundamentally about control. [Medical savings accounts] give control to patients and physicians. Expanded use of private [medical savings accounts] would thwart the goals of advocates of nationalized health care and reduce the market for managed-care insurance.⁶

A multitude of factors can affect the success or failure of medical savings accounts as a device to fund health care. As a report issued by the American Academy of Actuaries points out, the relative tendency for people to spend or save health care dollars depends on who is paying.⁷ This phenomenon is known as the “induction effect” (since using someone else’s money tends to *induce* more health care spending). Quantification of this effect is somewhat subjective, according to the report. Many complex, interacting considerations affect induction; namely, current versus new plan design (including levels of deductibles and coinsurance); demographics of the insured population; the extent of managed care under current versus new plans; provider practice patterns; and the effectiveness with which new health care plans with medical savings accounts are communicated to consumers.⁸

For the Archer MSA program, its many restrictions and limitations—and the resulting administrative complexities—have affected the enthusiasm with which Archer MSAs are embraced by employers, consumers, and health insurance carriers alike. Utilization of Archer MSAs has accordingly been rather limited. Congress set a ceiling of 750,000 enrollees; but to date, only 100,000 (a high estimate) have participated nationwide.

Social Impacts

1. Extent to which medical savings accounts would be utilized by a significant portion of the population

Medical savings account plans do not appear to be uniformly attractive to everyone. They are most attractive to those who are not likely to use the funds to any great extent for health care expenses. This group generally comprises those who are relatively healthy and affluent. According to a 1998 study by the U.S. Government Accounting Office (GAO), insurers expected this market and priced their products accordingly. The insurers also reported marketing medical savings account products to “highly paid professionals, farmers and ranchers, partnership firms, and association groups.” Overall, the study found that consumer demand was lower than many in the industry had expected.

Responses to our survey appear consistent with the GAO’s finding. Generally, states that responded either did not know the extent of utilization or indicated very low utilization. Locally, several respondents appeared hopeful about the demand for medical savings account plans. The National Federation of Independent Business cites a survey it conducted a few years ago showing 67 percent of its members would use a plan with medical savings accounts. Its membership comprises approximately 5,000 local small business owners. The Hawaii Employers Council also indicated that its members would consider medical savings account products, if they become legal under the Hawaii Prepaid Health Care Act. Its membership comprises 700 Hawaii employers, from small family businesses to large corporations.

In contrast, University Health Alliance, which had unsuccessfully proposed a medical savings account package to the Department of Labor and Industrial Relations in 1997, predicts low utilization due to the high deductible associated with medical savings account products. Kaiser Permanente Hawaii (Kaiser Permanente) notes no demand for medical savings account products from its customers.

Hawaii Medical Service Association (HMSA) believes it is likely that the lower cost of medical savings account products will appeal to current and potential consumers among small businesses. However, if medical savings account products fail to secure the requisite approval from the Department of Labor and Industrial Relations, the only resulting market would be the self-employed. In that case, HMSA envisions only a small number buying such products, partially due to the high deductible, which it sees as associated with potentially large out-of-pocket costs for the insured.

2. Extent to which medical savings accounts are already generally available within the State

Plans with Archer MSAs are currently not available in Hawaii. The Department of Commerce and Consumer Affairs is not aware of any group plans with medical savings accounts being offered in Hawaii at this time, but believes “there is no statutory restriction on individuals purchasing [medical savings account] plans for themselves and their families.” However, the Hawaii Employers Council’s position is that such plans do not comply with requirements of the Prepaid Health Care Act. HMSA attributes the current unavailability largely to past administrative opinions regarding the feasibility of offering medical savings accounts to employers while complying with requirements of the Prepaid Health Care Act.

We note that American Health Value, based in Boise, Idaho, claims to be offering nonqualifying medical savings account plans in all fifty states.¹¹ This carrier is not certificated by the Department of Commerce and Consumer Affairs. It is an unsettled question as to whether out-of-state carriers that perhaps sell health care policies via the Internet, with no physical presence in Hawaii, require certification. If this particular insurance carrier were certified, it would be required to file rates for its medical savings account product. To date, no carrier has filed rates for such a product with the Insurance Commissioner.

We note also that the Department of Labor and Industrial Relations has received a health care plan from a private employer (who is self-insured) that includes a “personal care account” similar to a medical savings account. The elements of the plan, however, would not qualify it for pairing with an Archer MSA.

Of the responding states, the availability of medical savings accounts varied. Some states reported several to a few carriers offering medical savings account products. Others have none or very limited availability. Maryland has only one known company, Golden Rule. The carrier limits sales to self-employed members of an association covered under an out-of-state contract.

3. Extent to which the lack of medical savings accounts would result in persons being unable to obtain necessary health care treatment

Medical savings accounts will very likely not affect a person’s ability to obtain necessary health care treatment. They are, after all, a means to pay for health care costs, not a tool for health service delivery. As a result, most survey respondents did not provide an answer, or saw the lack of medical savings accounts as having no impact on the ability of

individuals to obtain necessary health care treatment. Also, alternative health care plans are already available for obtaining health care treatment.

Arkansas points out, however, that an uninsured person who is also between jobs could pay for health care expenses out of a medical savings account, thereby obtaining necessary health care treatment.

4. Extent to which lack of medical savings accounts results in unreasonable financial hardship on those persons needing treatment

The lack of medical savings accounts would not result in unreasonable financial hardship, as pointed out by a number of respondents. Alternative health care plan options are already available to individuals and to those having access to group plans. As HMSA pointed out, 88 percent of Hawaii's population receive health care coverage through employers.

5. Level of public demand for medical savings accounts

Most survey responses reflected either an unawareness of the level of demand or very little public demand for medical savings account products. Where inquiries on medical savings accounts have been received, they have come from the self-employed (Maine), individual employers (Minnesota and Ohio), and those looking for less costly coverage through high-deductible plans (HMSA).

The Department of Commerce and Consumer Affairs, however, sees a growing number of groups interested in medical savings accounts: small employers (for the federal and state tax advantages); doctors (for a way to reduce administrative paperwork and costs and to receive payment faster); and consumers (for a way to manage their own health care expenditures and to carry over funds in medical savings accounts from year-to-year).

6. Level of public demand for individual and group insurance coverage in relation to medical savings accounts

Public demand for individual and group insurance coverage in relation to medical savings accounts may vary. The GAO study pointed out that health maintenance organizations (HMOs) believe a high-deductible health care plan, a requirement for Archer MSAs, is inconsistent with the concept of an HMO.¹² The American Academy of Actuaries study similarly noted the philosophical difficulties in integrating medical savings accounts into an existing system such as an HMO.¹³

The GAO found that among insurers offering qualifying plans, preferred provider organizations (PPOs) are the most common type; traditional indemnity plans are also widely available. On the other hand, HMOs, exclusive provider organizations, and point-of-service plans (among others) are rarely available as qualifying plans.¹⁴

The consensus among those responding to our survey question appears to be low or no demand for medical savings accounts in individual and group insurance coverage.

7. Level of interest of collective bargaining organizations in negotiating privately for inclusion of medical savings accounts in group contracts

Most state responses to our survey indicated an unawareness of the level of interest of collective bargaining organizations in negotiating for medical savings accounts in group contracts. Other responses indicated that unions express no, or very little, interest. The lack of interest may be because medical savings accounts are targeted at small employers. HMSA makes a similar observation: that collectively bargained organizations are generally larger than 50 employees and would therefore not be eligible for medical savings accounts. Ohio observed that “[c]ollective bargaining organizations generally oppose consumer driven health insurance plans, including coverage that involves medical savings accounts.”

Locally, labor unions either detect no interest in negotiating for inclusion of medical savings accounts (HGEA, Hawaii Teamsters and Allied Workers Union Local 996) or are still considering the advantages and disadvantages of providing medical savings accounts (Hawaii State Teachers Association). The Hawaii Employers Council indicated no demand for inclusion of medical savings accounts in health care plans from the unions with which it negotiates. The State of Hawaii Organization of Police Officers (SHOPO), however, suggests that medical savings accounts ought to be part of a benefit package contract (although by its other responses, it appears that SHOPO may be equating medical savings accounts to flexible spending accounts).

8. Impact of medical savings accounts on health status, quality of care, practice patterns, or provider competition

Medical savings accounts may impact health status, quality of care, practice patterns, and provider competition in various ways. Integrating medical savings accounts into an existing system, such as HMOs, may present philosophical difficulties, among others. One positive and essential feature of HMOs is easy access to primary and preventive care, with full coverage. To the extent a medical savings account plan

motivates enrollees to avoid spending money for such care, physicians may perceive a loss of control over their patients' acute illness and chronic conditions.¹⁵

HGEA points out that the health status of individuals may be adversely affected if patients put off or cannot afford medical care. HGEA also believes that the organized influence on providers to improve health care quality would be diminished; provider competition would diminish as well because of the lessening influence of large health care purchasers. On the other hand, as HMSA suggests, consumers may be more apt to "shop around" since they must pay out-of-pocket for health care services until the high-deductible amount is reached. More market competition may encourage providers to competitively price their services.

Although a supporter of medical savings accounts during the 2003 legislative session, HMSA points out a possible negative impact, similar to those indicated by HGEA. The tax advantages that accrue to the funds in medical savings accounts may tempt consumers to delay or entirely avoid preventive care such as pap smears, mammograms, and prostate cancer screenings. The possibility of substantial savings may outweigh health considerations. HMSA offers this tempting example:

If a 20-year old (or his employer) places \$1,800 a year into a medical savings account, and the funds are never used (assuming an 8 percent return on investment), the account would be worth \$11,404 after five years, \$142,118 after 25 years and \$751,367 after 45 years (at retirement).

Delaying or forgoing preventive health care may thus lead to long-term health care costs, a view shared by the Longshore and Warehouse Union International Local 142.

University Health Alliance observes that possible tax savings achieved by medical savings accounts may improve access to health care. Large deductibles, however, may present collection problems for providers.

Most state responses indicated that the impacts on health status, quality of care, practice patterns, or provider competition are unknown. Those that did respond expect very small or no impact, or no negative impact. The absence of an impact may stem from low interest in medical savings accounts (Maryland, Ohio). In Hawaii, the Department of Commerce and Consumer Affairs believes that there should be no negative impact, given the regulatory environment here. Arkansas expects improvement in all these categories over time.

9. Impact of indirect costs upon the costs and benefits of medical savings accounts

The costs and benefits of medical savings accounts may be impacted by certain indirect costs. Increases in out-of-pocket costs may diminish the benefits of medical savings accounts for some consumers. Under a medical savings account arrangement, funds in the account are expected to cover costs left for payment by the insured by virtue of the linked insurance policy's high deductible. Those finding medical savings account arrangements attractive tend to be healthier and younger. These individuals would probably find that funds in their medical savings accounts are sufficient to cover their annual health care costs. However, those faced with catastrophic illnesses or other high medical expenses, especially in the early years under a medical savings account arrangement, may find the level of funds in their accounts outstripped by the deductible under their policy. For these individuals, out-of-pocket expenses would be significantly increased, in contrast to coverage under a more traditional health care plan. See example below.

Example No. 3

Lydia Doe is a single mother of two children with a medical savings account and a \$4,800 high-deductible health care plan. She can have \$3,600 in her medical savings account during the first year. If she needs to trigger coverage under her health care plan, she would be required to pay the \$1,200 difference between the plan's deductible of \$4,800 and the \$3,600 in her medical savings account. Of course, this assumes that her account is fully funded at the time the medical need arises. Otherwise, she would be paying even more out-of-pocket to cover the deductible amount. If Lydia is earning poverty level wages (\$14,269 for a family of one adult and two children based on Census Bureau figures), \$1,200 would be 8.5 percent of her annual earnings, or more than she would earn pre-tax in one month.

HMSA presents a number of negative impacts among stakeholders:

1. *Employers:* May experience increased costs associated with administering a health plan with medical savings accounts. There may also be costs associated with educating oneself about changes in health care plans and financial complexities associated with medical savings accounts.
2. *Consumers:* There may be start-up and annual fees charged by financial institutions handling medical savings accounts.

3. *Health care plan providers:* For HMSA, existing internal infrastructure appears capable of handling administrative changes required by medical savings accounts. However, it sees significant start-up costs to accommodate electronic co-payment information transfers to pertinent financial institutions.
4. *Health care providers:* May see additional costs associated with collecting payments directly from patients for services rendered. If medical savings accounts result in greater shopping behavior among consumers, providers may incur additional costs associated with marketing and advertising their services.

Among the states that responded, most did not provide an answer to this particular issue. The substantive responses varied. Arkansas sees a lessening in health care costs from a reduction in utilization and administrative costs (from the higher deductible), as does the Department of Commerce and Consumer Affairs. Maryland and Nebraska see no impacts, while Minnesota believes that more individuals would be insured.

There may also be losses in tax revenues for states that tie in their income determinations to federal guidelines, as contributions to medical savings accounts and qualified spending from these accounts are tax-deductible, and interest earned on the funds in these accounts is tax-free.

Financial impacts

1. Extent to which medical savings accounts would increase or decrease health care costs

The impact that medical savings accounts would have on health care costs depends on one's perspective. Under traditional health care plans with comprehensive coverage, an employer very likely pays high insurance premiums for its employees. If the employer maintains the same level of expenditure but converts to high-deductible health care plans with medical savings accounts, employees will benefit from the cost savings by the employer's contribution to their medical savings accounts. The employer in turn receives a tax benefit from the contributions to employees' medical savings accounts.

However, the increase in co-payments that employees must make will be greater than the premium reduction to the employer. As a result, some employees will pay more for health care under medical savings account plans. Employees with little or no health care expenses will realize greater savings; those with substantial health care expenses will incur greater losses. And those with substantial expenses tend to be older employees and pregnant women.

HMSA believes that consumers may experience initial savings on premium costs (since a high-deductible plan is less expensive than a comparable low-deductible plan). However, a consumer must pay for health care services up to the deductible amount of his or her insurance policy, either out-of-pocket or with medical savings account funds. Under this circumstance, the consumer may elect to delay or avoid health care services, particularly preventive ones. This behavior may result in greater long-term health care costs.

Further, HMSA points out, as do other studies, that younger and healthier employees are most likely to opt for health care plans with medical savings accounts. Requiring fewer health care services, these employees are able to accumulate funds in their medical savings accounts to take advantage of tax-free earnings. The remaining population of employees, however, would consist of older and less healthy individuals, who tend to require more health care services. Thus, while the cost of health care for those participating in medical savings account plans would likely decrease, those remaining in traditional plans could see a significant rate increase.

Kaiser Permanente sees a possible shift in cost-bearers from employers to employees, as trade-offs are made from up-front costs to point-of-service costs. Under existing traditional health care plans, up-front costs are higher (i.e., premium costs borne by employers), with lower costs at the point of service (borne by employees). Under health care plans with medical savings accounts, the up-front costs may be lower for employers (unless the employer contributes net savings into the employee's medical savings account). The employee's out-of-pocket costs increase, however, under this scheme at point-of-service.

University Health Alliance notes the tax savings that would accrue to those who are currently uninsured who opt for health care plans with medical savings accounts. The insurer, however, acknowledges the complexities of shifting from employer-based to individual-based health insurance in assessing the impact on health care costs.

Most states did not provide an answer on this issue. Among those that did respond, the impact was generally seen as minimal. A few believe that medical savings account plans would decrease health care costs. The Department of Commerce and Consumer Affairs holds the view that medical savings accounts should help control and reduce the overall costs of health care.

2. Extent to which medical savings accounts would increase the use of health care services

Use of health care services under a medical savings account plan may vary, depending on the consumer. A high co-payment requirement under a high-deductible health care plan may induce a reduction in health care utilization. However, the existence of funds in a medical savings account may counteract this utilization reduction, depending on whether the consumer views the account as simply another form of insurance or as personal savings.

In the first instance, utilization may remain unaffected under a low-versus a high-deductible plan, since funds in the MSA would be equivalent to payment by a third-party. In the latter case, utilization may well be reduced because of an incentive to preserve the funds in what the consumer views as his or her personal savings account.

For states that provided substantive responses to our survey, the experience generally has been that medical savings accounts have had no effect on utilization essentially because of low utilization of plans with these accounts. There is an expectation among some states that health care service usage will decrease because consumers would be more careful in their health care spending. HMSA also believes that more careful spending may occur. However, HGEA expects that, with a possible decrease in primary health service utilization, acute health care service utilization could increase.

Kaiser Permanente sees consumers taking a cautious approach to health care service utilization, but only until the out-of-pocket or deductible ceilings are reached. Thereafter, however, consumers would have less incentive to purchase additional health care services wisely.

3. Extent to which medical savings accounts would serve as an alternative for more expensive treatment or service

This particular issue may not be applicable to medical savings accounts. As some respondents pointed out, medical savings accounts are not alternatives for more expensive treatment or service, but a means of paying for treatment or service. University Health Alliance added that the means of treatment is a decision between patient and provider; whereas health care plan providers focus mainly on type and level of benefits, which are other, separate issues.

Nonetheless, some respondents see medical savings accounts as a means of encouraging consumers to use less expensive solutions to medical problems (Arkansas) or to reduce high utilization initially because of the high deductible (Minnesota).

Kaiser Permanente noted that, in any case, the availability of medical savings accounts is unlikely to impact consumers' use of expensive treatment or service. Most in-patient and many out-patient procedures are apt to cost more than the medical savings account funds and the deductible, and would therefore be covered by the health care plan. Moreover, those consumers anticipating or suspecting a need for expensive treatment in the future are least likely to enroll in a high-deductible/medical savings account health care plan, if other alternatives are available.

4. Extent to which medical savings accounts would increase or decrease insurance premiums or administrative expenses of policyholders

The implementation of medical savings account products may decrease insurance premiums for some individuals, but may increase costs for other policyholders. Medical savings account packages have the potential to produce the effect known as adverse selection. This term applies to the process that occurs when healthy people migrate to one insurance pool, while those less well remain in another. This can lead to escalation of premiums in the pool containing more who are less well.

Medical savings account packages tend to attract those who are young and healthy. These individuals would gain financially under high-deductible health care plans, which are generally less expensive than traditional, more comprehensive plans. However, for those remaining with comprehensive plans, premiums may rise. Or, if they switch to medical savings account plans, their out-of-pocket expenses will increase. Both HMSA and Kaiser Permanente suspect that adverse selection may operate to raise premium expenses over time for traditional comprehensive coverage.

Some states, and the Department of Commerce and Consumer Affairs, point out the decrease in insurance premiums under medical savings account plans. However, as Kaiser Permanente noted, premium increases for medical savings account plans may occur over time due to "leveraging." Leveraging occurs when the deductible amount remains constant even as the underlying cost structure increases. Remaining constant, the deductible amount covers a diminishing share of the total cost of health care. This phenomenon leads to premiums increasing faster than the underlying cost structure.

Perhaps existing state law may provide some protection against effects such as adverse selection and leveraging. Under the Insurance Code, the insurance commissioner may mandate health insurance rate filings when he has "actuarially sound information that current rates may be

excessive, inadequate, or unfairly discriminatory.”¹⁶ He may also disapprove rate filings that do not meet statutory requirements.¹⁷

Both Kaiser Permanente and University Health Alliance expect some upward impact on administrative costs. There will be increased costs associated with tracking payments from medical savings accounts and with such mechanisms as stored-value cards that give members access to funds. There would also be administrative costs associated with record-keeping for tax purposes associated with medical savings accounts for both the insurance company and the employer.

5. Impact of medical savings accounts on the total cost of health care

Medical savings accounts may reduce the total cost of health care (Arkansas, because a consumer is purchasing services instead of receiving them “practically free” with insurance coverage; Minnesota, because more individuals would be insured). However, more states see very little or no effect (Maryland, Nebraska, Ohio, and Utah). The Department of Commerce and Consumer Affairs anticipates that overall health costs will decrease as consumers manage their health care utilization and as administrative costs for providers decrease from a reduction in paperwork and more timely payments for services.

Kaiser Permanente noted that proponents expect medical savings accounts to help keep costs in line. However, the insurer believes it unlikely that medical savings accounts will help to lower total health care costs, or even to reduce the overall rate of increase in costs. It cited a recent report by the Employee Benefit Research Institute, which finds that the costliest 10 percent of non-elderly individuals with employer-based insurance account for 58 percent of health care expenditures. On the other hand, the least costly 63 percent of individuals account for just 11 percent of expenditures. The costliest 10 percent are more apt to either stay with traditional comprehensive coverage or use medical savings accounts as insurance payments, rather than as savings, and rely on the high-deductible plan as they would under standard preferred provider organization coverage. Accordingly, the overall cost of health care would not be impacted.

Kaiser Permanente suspects further that medical savings accounts may in fact lead to an increase in the cost of health care because of adverse selection. Those who are younger and healthier will leave the risk pool of traditional health care insurance, pressuring the premiums for such insurance to rise. Or those with medical savings accounts may switch to more traditional coverage when more costly health care needs are anticipated—such as when a woman is expecting a baby—a further occurrence of adverse selection. HMSA offers a similar perspective.

HMSA anticipates consumers, motivated to maintain sizable balances in their medical savings accounts, may be tempted to delay or avoid preventive health care services. In the absence of other incentives to seek preventive services, such short-range decisions may result in long-term health care costs from undetected conditions or diseases. On the other hand, if consumers with medical savings accounts are motivated to shop around for the best health care value, providers may be encouraged to competitively price their services.

Other impacts

1. Extent to which medical savings accounts are used for workers' compensation purposes

Of the states that responded, none use medical savings accounts as a means to fund health care expenses associated with workers' compensation claims. Locally, HGEA would oppose the use of medical savings accounts for workers' compensation purposes (and for health care purposes as well). It believes that the risk of on-the-job injuries and medical expenses ought to be borne by large groups, not individuals. The assumption underlying the proposed use of medical savings accounts for workers' compensation and health care expense purposes is that an individual has a substantial degree of control over health status or on-the-job-injury. HGEA rejects this assumption, and feels that the proposed use of medical savings accounts will penalize those who are already suffering from injury or illness.

Other local labor unions would need to study this issue further (Hawaii State Teachers Association) or would discourage use of medical savings accounts for workers' compensation purposes (Longshore and Warehouse Union International Local 142).

2. Extent to which medical savings accounts are available to public employees

No responding state offers medical savings accounts to public employees. Arkansas is looking at offering "health reimbursement accounts" to its public employees. These accounts are probably based on an Internal Revenue Service ruling, according to the state. By concurrent resolution, Texas is asking Congress to broaden the scope and availability of the federal medical savings account program, remove current restrictions, and permit state governments to design such programs for their employees.

3. Extent to which Hawaii health care plan providers would offer plans with medical savings accounts

HMSA would market medical savings accounts to sole proprietors and small employers, considering the following factors:

- The sunset date for Archer MSAs of December 2003 is extended or repealed by Congress;
- A medical savings account health care package for sole proprietors and small employers is acceptable to the Prepaid Health Care Advisory Council and the director of the labor department; and
- If limited strictly to sole proprietors, HMSA would offer a high-deductible plan without the medical savings account element. The size of the self-employed market is very small, and no local financial institution has been willing to administer the trust functions of medical savings accounts.

Kaiser Permanente would consider the following factors in deciding to offer plans with medical savings accounts:

- Quality and coordination of care for its members;
- Risk pool fragmentation;
- Insurance environment in Hawaii;
- Competitors' offerings;
- Consumer demand;
- Extent to which benefit design and financing permits the consumer to finance health insurance premiums for an integrated health care plan like Kaiser Permanente;
- Comprehensive benefit package;
- Cost effectiveness; and
- For group plans, a favorable ruling from the Department of Labor and Industrial Relations.

University Health Alliance would probably not actively market a medical savings account product. It considers itself too small a company to make marketing this product operationally feasible. The factors pertinent to its

marketing decision are market assessments, underwriting, product offerings, operating issues, provider issues, administrative expenses, and educational training. Hawaii Management Alliance Association did not respond to our survey.

Conclusion on social and financial impacts

Cautious consideration of the social and financial impacts of medical savings accounts is warranted. If medical savings accounts are established in Hawaii, the experience of other states may be repeated here—in which case, medical savings accounts should have little or no impact on health care costs or practices because of relatively low enrollment. Possible risk-shifting through adverse selection, however, may require institution of some preventive measures or contingencies.

Future Implications

If enacted, proposed federal legislation would broaden the scope and application of medical savings accounts and may negatively impact lower income taxpayers and those most in need of health care. Further, such legislation may result in substantial tax revenue loss to Hawaii.

Currently, medical savings accounts have limited applicability under the pilot project created by HIPAA. The pilot project is scheduled to sunset in December 2003. A GAO study and responses to our survey show low enrollment in health care plans offering medical savings accounts. Consequently, the impact of medical savings accounts has been minimal and may be minimal for Hawaii.

On June 26, 2003, the U.S. House of Representatives passed Bill No. 2596 that in essence expands the scope of medical savings accounts (renamed “health savings accounts”) and that also establishes a new tax-advantaged health funding mechanism called “health savings security accounts.” Lacking income limits and a sunset deadline, health savings accounts may be established by any taxpayer. Medical savings accounts are, on the other hand, limited to the self-employed and employees of small employers.

In addition, health savings security accounts would be available to taxpayers who are either uninsured or covered by a high-deductible health insurance policy that is not necessarily provided by an employer. Income limits apply, but are rather generous: \$170,000 for couples; \$85,000 for individuals. Both health savings accounts and health savings security accounts have tax advantages similar to medical savings accounts and individual retirement accounts.

Without the same restrictions placed upon medical savings accounts, these proposed accounts will very likely appeal to the more affluent and

healthier segment of the nation's population (including Hawaii's population). The sunset date set for medical savings accounts would no longer be a bar to health care plan insurers, who can offer plans with health savings accounts or health savings security accounts without the threat of a termination date. The adverse selection phenomenon that did not materialize under the medical savings account pilot project may well occur with health savings accounts and health savings security accounts. The result would be higher premiums for the older and less healthy segment of the population as the young and healthy leave the risk pool of comprehensive health insurance coverage for less expensive high-deductible plans with health savings accounts and health savings security accounts.

A report by the Center on Budget and Policy Priorities characterizes these tax-advantaged personal savings accounts as tantamount to a tax cut for some taxpayers. The Joint Tax Committee estimates the tax consequences to be at a cost of \$173.6 billion over ten years.¹⁸

The possible loss of revenue to states stems from deductions allowed for deposits into these tax-advantaged accounts that reduce a taxpayer's adjusted gross income. Where states link their own income tax calculations to the federal adjusted gross income, loss of tax revenue may result. As projected by the report, the State of Hawaii stands to lose \$900,000 in tax revenues in 2004. Thereafter, the projected revenue losses rise sharply: \$5.5 million in 2005, and \$9.9 million in 2006. Over the long term of 2004 to 2013, the report projects revenue losses of \$208 million for Hawaii.¹⁹

The Center on Budget and Policy Priorities suggests that detaching from these proposed tax breaks may be one way for states to avoid revenue losses.²⁰ Such a move, however, may prove to be difficult from a political and policy standpoint. Strengthening both the review process under the Prepaid Health Care Act and health insurance rate regulation may provide some protection against the negative financial impacts of adverse selection.

LINDA LINGLE
GOVERNOR



MARK J. BENNETT
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July 8, 2003

The Honorable Marion M. Higa
State Auditor
465 S. King St., Rm. 500
Honolulu, HI 96813-2917

Dear Ms. Higa:

Re: Medical Savings Accounts

You asked by letter dated June 13, 2003, the following three questions:

- (1) Whether medical savings accounts would affect Hawaii's exemption to preemption under the federal Employee Retirement Income Security Act (ERISA);
- (2) Whether legislation allowing the creation of medical savings accounts would be preempted under ERISA; and
- (3) Whether medical savings accounts can be consistent with the minimum package of benefits required under the State's Prepaid Health Care Act.

The short answers to your questions are as follows:

- (1) Medical savings accounts would not affect Hawaii's exemption to preemption under ERISA.
- (2) Whether legislation allowing the creation of medical savings accounts would be preempted depends upon the legislation. H.B. No. 450 would likely be subject to preemption, H.B. No. 1167 would probably not be subject to preemption, and H.B. No. 1293 is exempt from provisions of ERISA and not subject to preemption.
- (3) We believe it is possible for medical savings accounts to be utilized and satisfy the requirements of the Prepaid Health Care Act.

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A brief overview regarding the ERISA preemption and Hawaii's exemption from ERISA may be helpful for an understanding of the interplay between state laws and ERISA preemption. ERISA is a comprehensive federal legislative scheme that regulates the administration of private employee benefit and pension plans and establishes standards relating to the administration of these plans. In enacting ERISA, Congress included a sweeping preemption provision that provides in relevant part, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" 29 U.S.C.A. § 1144(a).¹ As you are aware, the Hawaii Prepaid Health Care Act ("PHCA") enjoys a narrow exemption from ERISA preemption by virtue of 29 U.S.C.A. § 1144(b)(5)(A).² That exemption applies only to the PHCA as it existed on September 2, 1974 and amendments to the PHCA "to the extent it provides for more than the effective administration" of the PHCA. 29 U.S.C.A. § 1144(b)(5)(B)(ii).³

Thus, any state law that "relate[s] to any employee benefit plan," including, but not limited to, the prepaid health care law, would be subject to preemption.⁴ That state law,

¹ The subsection, in full, provides as follows:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

² 29 U.S.C.A. § 1144(b)(5)(A) provides as follows:

Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

³ 29 U.S.C.A. § 1144(b)(5)(B)(ii) provides as follows:

Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section -

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

⁴ For amendments to the PHCA, the next inquiry would be whether the amendments fell within the permissible limits of the exemption from preemption for PHCA. For other state laws, the inquiry would be whether the state law fell into some exception or could otherwise be "saved" from preemption. 29 U.S.C.A. § 1144(b)(2)(A) provides, "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." See Metropolitan Life Insur. Co.

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however, would not jeopardize Hawaii's narrow exemption from preemption for the PHCA. It follows, then, that if a law were to be passed concerning medical savings accounts and such law "related to" employee benefit plans, the law would not jeopardize Hawaii's exemption from preemption for the PHCA, but would itself be subject to preemption.

Whether a state law allowing for the creation of medical savings accounts would be preempted by ERISA is a question that we are unable to answer without examining a legislative proposal. By telephone, your staff asked that if the question cannot be answered in general terms, that we address whether the three bills listed in House Concurrent Resolution 93 – H.B. Nos. 450, 1167, and 1293 – would be preempted by ERISA.

State law is subject to preemption if it "relates to" an employee benefit plan. State law "relates to" an employee benefit plan if it has a "connection with" or a "reference to" employee benefit plans. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2900 (1983); Southern California IBEW-NECA Trust Funds v. Standard Indus. Elec. Co., 247 F.3d 920 (9th Cir. 2001). "To find an impermissible connection, . . . [the courts] look 'both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.' . . . A statute has an impermissible 'reference to' an employee benefit plan if it acts immediately and exclusively upon the plans or if the plans are essential to the law's operation." Id. at 925 (citations omitted). If the state law "relates to" an employee benefit plan, then it is subject to preemption, but can be "saved" from preemption because it regulates insurance, banking, or securities. 29 U.S.C.A. § 1144(b)(2)(A); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 365, 122 S. Ct. 2151, 2159 (2002).

Under ERISA, an employee benefit plan includes both an "employee welfare benefit plan" and an "employee pension benefit plan." 29 U.S.C.A. § 1002(3). The bills you asked us to analyze do not address pension plans, so we examine the meaning of "employee welfare benefit plan." It is defined as follows:

any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or maintained for the purpose of providing for its participants or its beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, . . . or (B) any benefit described in section

v. Massachusetts, 471 U.S. 724, 105 S. Ct. 2380 (1985). We note, however, that simply because an amendment is made to the insurance laws, it does not automatically escape ERISA preemption; the amendments must meet the court's test for regulation of insurance. Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. ___, 123 S. Ct. 1471 (2003).

186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C.A. § 1002(1). However, provisions of ERISA do not apply if “(1) such plan is a governmental plan (as defined in section 1002(32) of this title); . . . [or] (3) such plan is maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability insurance laws.” 29 U.S.C.A. § 1003(b)(1) and (3).

H.B. No. 450, is entitled “Relating to Workers’ Compensation.” The purpose of this bill is “to authorize employers to create individual medical trust accounts for each employee, funded by the employer, to provide direct coverage of health care expenses” because “[l]itigating workers’ compensation claims is a major cost for many employers.” H.B. No. 450 at 1. The bill permits employers to establish individual medical trust accounts⁵ for its employees. The account can be used to pay for work-related medical expenses as well as lost wages. The bill also provides for the distribution of the funds in the individual medical trust account under various scenarios. In addition, the bill amends section 235-7, a tax provision on exclusions from gross income, adjusted gross income and taxable income; and various sections of chapter 386, the workers’ compensation law.

Because H.B. No. 450 would create a “fund . . . established . . . by an employer . . . for the purpose of providing for its participants . . . medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death,” it falls into the definition of an “employee benefit plan.” This fund, however, pays for some, but not all, of the benefits ordinarily covered by workers’ compensation insurance⁶ in addition to giving funds for non-workers’ compensation purposes. If the plan were “maintained solely for the purpose of complying with applicable workmen’s compensation laws,” then it would not be subject to provisions of ERISA and not be subject to preemption.

The Hawaii workers’ compensation law does not provide for individual medical trust accounts to satisfy an employer’s obligation to provide workers’ compensation coverage for its employees. See H.R.S. § 386-121. In addition, these accounts that may be established by

⁵ Although you ask about medical savings accounts, this legislation refers instead to “individual medical trust accounts.” Medical savings accounts meeting the requirements of federal law have favorable federal and state tax treatment. Section 220 of the Internal Revenue Code; H.R.S. § 235-2.4(f). The individual medical trust accounts do not appear to satisfy the requirements for treatment as a medical savings account under federal law.

⁶ It is not clear how the provisions of this bill are supposed to integrate with all the requirements of chapter 386, the Workers’ Compensation Law, and also raises many questions concerning the actual operation of this account.

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employers are not only for workers' compensation benefits. Rather, this bill allows for the disposition of the individual medical trust accounts as follows: (1) a refund to the employer of all of employer's contributions to the fund when the employee is no longer able to work for the current employer; (2) upon request by the employee, a distribution of five percent to the employee where the fund balance is above \$12,000.00; (3) upon request by the employee upon reaching age sixty, a distribution to the employee of one-third of the balance of the account; (4) payment of health insurance premium payments and any co-payments or other health expenses upon retirement of the employee; (5) a distribution to the employee, at the employee's option, upon the employee reaching age seventy; and (6) upon death of the employee and application by the personal representative, a transfer of the balance to the employee's estate. H.B. No. 450, section 2 (§ 386-E). These provisions have nothing to do with an employer complying with Hawaii's workers' compensation laws and, thus, would not fall within the exception to coverage under ERISA for plans maintained "solely for the purpose of complying with applicable workmen's compensation laws." We conclude, therefore, that H.B. No. 450 would likely be subject to ERISA preemption, unless it can be saved from preemption under the insurance savings clause.

In order to be deemed a law that regulates insurance and be saved from preemption, the law "must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." Kentucky Ass'n of Health Plans, Inc., supra, 538 U.S. at ___, 123 S. Ct. at 1479 (citations omitted). H.B. No. 450 fails the first part of the two-part test, as it is directed to employers and not "toward entities engaged in insurance." H.B. No. 450, thus, would appear to be preempted by ERISA.

With respect to H.B. No. 1167, Relating to Medical Savings Accounts, we conclude it would probably not be subject to ERISA preemption. This bill authorizes insurers, mutual benefit societies, and health maintenance organizations to "offer high-deductible health insurance contract[s] to employers or self-insureds that establish medical savings accounts, as defined in section 220 of the Internal Revenue Code." Assuming that this bill "relates to" an employee benefit plan, it would appear to be saved from preemption under the insurance savings clause. This bill appears to satisfy the two-part test enunciated by the U.S. Supreme Court in Kentucky Ass'n of Health Plans, Inc., supra. It is specifically directed toward entities engaged in insurance. All three entities, insurers, mutual benefit societies, and health maintenance organizations, are authorized to provide health and other insurance coverage. This bill also substantially affects the risk pooling arrangement between the insurer and the insured as it authorizes the sale of another product, high-deductible health insurance contracts, "altering the permissible scope of bargains between insurers and insureds." Thus, we conclude that H.B. No. 1167 would most likely not be subject to ERISA preemption.

Finally, H.B. No. 1293, Relating to Medical Savings Accounts in the Employer-Union Health Benefits Trust Fund, is probably not subject to ERISA preemption. H.B. No. 1293

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requires the employer-union health benefits trust fund to establish a medical savings account plan option and to purchase a high-deductible health plan. A "governmental plan" is exempt from ERISA. Hall v. Maine Mun. Employee Health Trust, 93 F. Supp. 2d 73 (D. Me. 2000). A governmental plan is "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing." 29 U.S.C.A. § 1002(32).

The employer-union health benefits trust fund was established by the Legislature in 2001 "by repealing the existing [Hawaii Public Employees] Health Fund and replacing it with an employer-union trust structure to provide a single health benefits program for public employees, retirees, and their dependents." Conf. Comm. Rep. No. 124, Haw. S.J. 909, 910 (2001). The fund is to be administered by a board of trustees, appointed by the Governor, "to provide employee-beneficiaries and dependent-beneficiaries with health and other benefit plans." H.R.S. § 87A-31(a). The Legislature thus created a State trust fund to provide medical and other benefits for its employees. Thus, it falls within the definition of a governmental plan. Because H.B. No. 1293 simply amends the chapter relating to the employer-union health benefits trust fund, which we believe to be exempt from ERISA, the amendment would similarly not be subject to ERISA.

We cannot guarantee that a court would agree with our ERISA analyses above, if the bills became law and were challenged. We hope, however, that the foregoing has provided you with sufficient information to assist you with your study.

Lastly, you ask us to address whether medical savings accounts can be consistent with the minimum package of benefits required under the PHCA. We believe that it is possible. The PHCA requires employers to provide health care coverage to their eligible employees by either "(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or (2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care." H.R.S. § 393-12(a).⁷ A prepaid health care plan meets the requirements of the PHCA by satisfying either subsection (a) or (b) of section 393-7, H.R.S., as follows:

(a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This

⁷ This is generally accomplished through plans offered by insurers, mutual benefit societies, and health maintenance organizations, but employers can also satisfy their obligation through self-insurance.

applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director [of labor and industrial relations], after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

Thus, a plan can qualify and meet the requirements of the PHCA by either: (a) being a plan which has the largest numbers of subscribers in the state (known as the prevalent or (a) status plans) or; (b) a plan which provides for sound basic hospital, surgical, medical, and other health care benefits, taking into account the limitations, co-insurance, and deductibles (referred to as (b) status plans) as determined by the Director of Labor and Industrial Relations ("Director"). The minimum benefits required by the Act are specified in section 393-7(c), H.R.S.

The Director, with input from the Prepaid Health Care Advisory Council ("Council"), has some flexibility⁸ in the kinds of (b) status plans that are approved. Thus, it is possible that employers could offer high-deductible health insurance coverage along with a medical savings account to their employees and at the same time comply with the PHCA. This assumes that the qualifying high-deductible health insurance plan has the requisite benefits that provide for sound basic hospital, surgical, medical, and other health benefits pursuant to section 393-7(b)⁹ and would not conflict with the requirements of the PHCA. This also assumes that the Director will be satisfied with the limitations, co-insurance, and deductibles of the plan. See H.R.S. § 393-7(b).

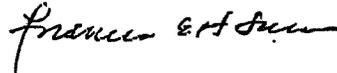
⁸ Section 12-12-7 provides, "The council shall have discretion in determining which plans qualify under section 393-7, H.R.S."

⁹ We are not aware that federal law specifies the types of benefits that a high deductible health plan must have.

The Honorable Marion M. Higa
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We understand that the Director has approved (b) status plans that have deductibles of up to \$250.00 with a maximum out-of-pocket expense of \$2,000.00. We further understand that a high-deductible health plan, as defined by section 220 of the Internal Revenue Code, 26 U.S.C.A. § 220, has a deductible amount and out-of-pocket expense ceiling much higher than the deductible and out-of-pocket expense ceiling that has been approved by the Director for (b) status plans. Nevertheless, if the employer, by utilizing the medical savings account or otherwise, can satisfy the Director that the benefits, including the limitations, co-insurance, and deductibles meet the requirements of section 393-7(b), then employers will be able to comply with the PHCA and also take advantage of section 220 of the Internal Revenue Code.

Very truly yours,



Frances E. H. Lum
Deputy Attorney General

Approved:



Mark J. Bennett
Attorney General

U.S. Department of Labor

Employee Benefits Security Administration
Washington, D.C. 20210

AUG 14 2003

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STATE OF HAWAII

The Honorable Marion M. Higa
State Auditor
State of Hawaii
465 S. King Street, Suite 500
Honolulu, HI 96813-2917

Dear Ms. Higa:

This responds to your request for guidance on the application of section 514(b)(5)(B)(ii) of the Employee Retirement Income Security Act of 1974 (ERISA) to proposed Hawaii state legislation regarding medical savings accounts (MSAs). In connection with a feasibility study that you are preparing, you specifically requested clarification of guidance we provided to Hawaii's Director of Commerce and Consumer Affairs, Mark E. Recktenwald, in a letter dated March 17, 2003.

Our letter to Mr. Recktenwald concerned whether the proposed legislation would adversely affect the status of the Hawaii Prepaid Health Care Act (Hawaii Act) under ERISA § 514(b)(5)(B)(ii). As you know, section 514(b)(5) generally saves the Hawaii Act from preemption as a law relating to employee benefit plans under ERISA § 514(a). Section 514(b)(5)(B)(ii), however, provides that any amendment to the Hawaii Act after September 2, 1974, is not saved "to the extent that it provides for more than the effective administration of [the Hawaii] Act as in effect on such date."

You first asked for confirmation that, if the Hawaii Act were amended, only the "substantive amendment would be preempted and that the Hawaii Act itself, as it read on September 2, 1974, would not lose its exemption from ERISA preemption as a result of any preempted amendment." In our view, ERISA § 514(b)(5)(B)(ii) limits the application of the saving clause in § 514(b)(5)(A) to the Hawaii Act as in effect on September 2, 1974, and to any amendments to the extent they provide for no more than effective administration of the Act as in effect on such date. Enactment of an amendment not saved from ERISA preemption would not necessarily affect the preemption status of the remainder of the Act. Whether an amendment is severable from the remainder of the Hawaii Act, as it read on September 2, 1974, depends on the specific terms of the amendment involved. This reading of § 514(b)(5)(B)(ii) is consistent with Council of Hawaii Hotels v. Agsalud, 594 F.Supp. 449 (D.Hawaii 1984) in which the court found that a 1978 amendment that attempted to expand the Hawaii Act to cover collectively bargained plans was preempted by ERISA. In reaching this conclusion, the court did not suggest that the other pre-amendment provisions of the Hawaii Act were adversely affected.

You also asked for confirmation that an amendment to Hawaii's insurance code having an "indirect effect" on the Hawaii Act would not affect the Act's exemption from ERISA preemption. We assume this question concerns amendments to the State insurance Code that

would allow issuers to offer high-deductible health insurance contracts to employers that establish MSAs. Employers might seek to use such arrangements to meet their health benefit obligations under the Hawaii Act. As we noted in our letter to Mr. Recktenwald, ERISA § 514(b)(2) generally saves State insurance laws from ERISA preemption. This section provides, in relevant part, that:

(A) Except as provided in subparagraph (B), nothing in this title [Title I] shall be construed to exempt or relieve any person from any law of any State which regulates insurance

(B) Neither an employee benefit plan . . . , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts,

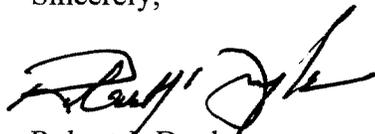
As we explained in our letter, § 514(b)(2) reserves to the States the right to regulate the business of insurance, but prevents States from regulating ERISA-covered employee benefit plans by deeming them to be insurers.

In the Department's view, an amendment to Hawaii insurance law authorizing insurers to sell high-deductible health insurance to employers who establish MSAs would not affect the Hawaii Act's exemption from ERISA preemption merely because employers may use such arrangements to satisfy their obligations under the Hawaii Act. ERISA § 514(b)(2), rather than § 514(b)(5), determines whether an insurance code amendment of this type is saved from ERISA preemption.

Finally, you asked whether MSA legislation that directly amends the Hawaii Act would be preempted under ERISA. The application of ERISA § 514(b)(5)(B)(ii) depends on the specific language of such an amendment. Without an opportunity to review such amendment, we are not able to answer this question. In addition, your letter did not appear to raise any issues under, and this letter does not address, any other provision of ERISA section 514(b)(5).

We hope this is of assistance to you. Should you have any questions concerning this letter, please feel free to contact me or the Chief of our Division of Coverage, Reporting and Disclosure, Joe Canary, at (202) 693-8523.

Sincerely,



Robert J. Doyle
Director of Regulations and Interpretations

Notes

Chapter 1

1. Section 393-7(d), HRS.
2. Sections 393-7(a) and (b), HRS.
3. Section 235-2.4(f), HRS.

Chapter 2

1. *Council of Hawaii Hotels v. Aghsalud*, 594 F. Supp. 449 (D. Hawaii 1984).
2. Sections 393-7(a) and (b), HRS.
3. Section 393-7(a), HRS.
4. American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, p. 10, Public Policy 1 Monograph (May 1995).
5. Marilyn Moon, Len Nichols, and Susan Wall Wallin, *Medical Savings Accounts: A Policy Analysis*, p. 6, Urban Institute (March 1, 1996).
6. Victoria Craig Bunce, *Medical Savings Accounts: Progress and Problems under HIPAA*, p. 2, Policy Analysis No. 411 (August 8, 2001).
7. American Academy of Actuaries, *Medical Savings Accounts*, p. 3.
8. *Ibid.*, p. 4.
9. U.S. General Accounting Office (GAO), *Medical Savings Accounts: Results from Surveys of Insurers*, p. 15, GAO/HEHS-99-34 (December 1998).
10. *Ibid.*, p. 5.
11. Bunce, *Medical Savings Accounts*, p. 20.
12. GAO, *Medical Savings Accounts*, p. 11.
13. American Academy of Actuaries, *Medical Savings Accounts*, p. 12.

14. GAO, *Medical Savings Accounts*, p. 11.
15. American Academy of Actuaries, *Medical Savings Accounts*, p.13.
16. Section 431:14F-104(a), HRS.
17. Section 431:14F-105(h), HRS.
18. Edwin Park and Iris J. Lav, *What's in a Name? House Bill Would Change Name but not the Substance of a Proposed Expansion of Medical Savings Accounts*, p. 1, Center on Budget and Policy Priorities (revised July 8, 2003); Edwin Park, Joel Friedman, and Andrew Lee, *Health Savings Security Accounts: A Costly Tax Cut That Could Weaken Employer-Based Health Insurance*, p. 1, Center on Budget and Policy Priorities (revised July 8, 2003).
19. Iris J. Lav and Andrew Lee, *New Health Savings Security Accounts Could Reduce State Revenues by up to \$30 Billion Over the Next Ten Years*, p. 8-11, Center on Budget and Policy Priorities (revised July 8, 2003)
20. *Ibid.*, p. 2

Response of the Affected Agency

Comments on Agency Response

We submitted a draft copy of this report to the Department of Commerce and Consumer Affairs on October 3, 2003. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

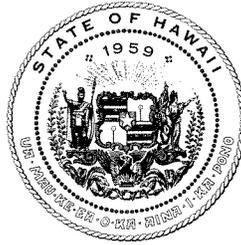
The department appears in general agreement with our findings. However, it believes that no additional enabling legislation is required to implement medical savings accounts. It supports its position by citing the state attorney general and the U.S. Department of Labor. We point out that the statements of these two agencies, in opinions given to the department as well as to the Office of the Auditor, were made in the context of assessing proposed enabling legislation. Therefore, the department's basis for stating that additional enabling legislation is not required is misleading.

The department also comments that all new health plans, not only those with medical savings accounts, must be approved by the director of labor and industrial relations and must meet the requirements of the Hawaii Prepaid Health Care Act. We made a similar observation, but only after noting the attorney general's belief that new health care insurance contracts combined with medical savings accounts can satisfy the requirements of the act—if such contracts provide benefits required under the act and do not conflict with other requirements of the act. As we noted, the attorney general's qualifying statements appear applicable to *any* health care plan proposal presented to the Department of Labor and Industrial Relations.

The Department of Commerce and Consumer Affairs goes further than our finding of minimal potential for any negative social and financial impacts of medical savings accounts by stating that medical savings accounts would not have *any* negative social or financial impacts. And, in fact, it believes that medical savings accounts would have a positive impact. However, we stand by our balanced presentation of advantages *and* disadvantages of medical savings accounts.

Finally, we note the attorney general's correction of an editing error in his opinion included in our report as Appendix A. His correcting letter is included in this report in Attachment 2, with the agency response from the Department of Commerce and Consumer Affairs.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor
(808) 587-0800
FAX: (808) 587-0830

October 3, 2003

COPY

The Honorable Mark. E. Recktenwald
Director
Department of Commerce and Consumer Affairs
Kamamalu Building
1010 Richards Street
Honolulu, Hawaii 96813

Dear Mr. Recktenwald:

Enclosed for your information are three copies, numbered 6 to 8 of our confidential draft report, *Medical Savings Accounts*. We ask that you telephone us by Tuesday, October 7, 2003, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, October 13, 2003.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

LINDA LINGLE
GOVERNOR



MARK E. RECKTENWALD
DIRECTOR

JAMES R. AIONA, JR.
LT. GOVERNOR

LAWRENCE M. REIFURTH
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS
1010 RICHARDS STREET
P. O. BOX 541
Honolulu, Hawaii 96809

October 13, 2003

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OFFICE OF THE AUDITOR
STATE OF HAWAII

Marion Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for the opportunity to comment on the draft report entitled, *Study of Medical Savings Accounts*. The Department of Commerce and Consumer Affairs (Department) continues to support initiatives that increase the health care coverage options available to businesses and workers. Because Medical Savings Accounts (MSAs) increase consumer health care coverage options, the Department supports enabling employers and employees to use this product.

The draft report identified two findings:

1. Legal issues related to MSAs are unresolved and subject to interpretation; and
2. Given the limited interest in MSAs nationwide, and very likely in Hawaii, the potential for any negative social and financial impacts of MSAs in Hawaii appears to be minimal.

Legal Issues

New legislation oftentimes requires interpretation. In this case however, the concept of MSAs is sound, and as noted by the Attorney General and the U.S. Department of Labor, MSAs can be offered to self-employed individuals and small employers in Hawaii without additional enabling legislation. Whether a particular MSA proposal would meet the requirements of the Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes) and be approved by the Director of Labor and Industrial

Relations must be determined on a case by case basis. However, this is also the case with other new health plans and is not unique to MSAs.

Social and Financial Impact

The Department believes that MSAs would not have any negative social or financial impact. In fact, from the Department's point of view, MSAs would have a positive impact.

The availability of MSAs would increase the options consumers have in financing their health care expenditures. Currently, consumers are limited in their options with one large preferred provider organization (PPO) and a major health maintenance organization (HMO) dominating the market.

Additionally, in the long-run, MSAs will likely contribute to a reduction in health care costs as incentives built into the MSA concept require that MSA participants utilize health care treatment more carefully. System over-utilization is one of the principle causes of increasing health care costs. MSA participation will reduce that tendency.

Attorney General Comments

As discussed with staff from the Office of the Auditor, we shared copies of the draft report with the Attorney General. The Attorney General indicated that the report accurately characterizes the advice that was contained in their July 8, 2003 letter to you. However, the Attorney General identified a minor change that should be made to that letter.

Enclosed for your convenience is a copy of the Attorney General's letter identifying the minor change.

Again, we appreciate the opportunity to comment on the draft report.

Very truly yours,



Mark E. Recktenwald
Director

Encl.

LINDA LINGLE
GOVERNOR



MARK J. BENNETT
ATTORNEY GENERAL

RICHARD T. BISSEN, JR.
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
425 QUEEN STREET
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(808) 586-1500

October 8, 2003

The Honorable Mark E. Recktenwald
Director of Commerce and
Consumer Affairs
State of Hawaii
1010 Richards Street
Honolulu, Hawaii 96813

DIRECTOR'S OFFICE
COMMERCE AND
CONSUMER AFFAIRS

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Dear Mr. Recktenwald:

Re: Auditor's Medical Savings Account Report

Thank you for the allowing us the opportunity to review the Auditor's Draft Report on Medical Savings Accounts. Based upon our review of the draft report, it appears that the report accurately characterizes the advice that our department gave to the Auditor in our letter of July 8, 2003. However, we did note that a minor change should be made to that letter. At page 2, in the first paragraph and in the second to the last sentence, the words "not to" should be added to the last sentence of that paragraph.

Consequently, that sentence of the letter should read as follows: "[t]hat exemption applies only to the PHCA as it existed on September 2, 1974 and not to amendments to the PHCA 'to the extent it provides for more than the effective administration' of the PHCA." Aside from this change, we have no additional comments to make concerning the draft report at this time.

Very truly yours,

Mark J. Bennett
Attorney General